Used with Permission – March, 2020; Dr. Teaessa Chism; Senior Associate Professor; Bellevue College

Overview of Clinical Day:

60- minutes pre individual research using EHR scenario, previous knowledge, and evidence-based care such as relevant guidelines of care or reference reading to begin to complete care plan.

Course Outcome-

60-minute Pre Team Huddle- Team will collaborate to answer pre team huddle questions and plan care.

Course Outcome-

180 minutes- Students will care for 2-3 virtual patients utilizing NurseThink vClinical; during these scenarios’ students will also reflect upon knowledge using Patient Care Section of this document to capture learning and link course concepts.

Course Outcome-

60 Minutes- Students will engage in Role Playing Scenarios based upon communication including patient, family education, escalation of care with SBAR and giving standard report of patients.

60 Minutes- Post Team Huddle discussing examples of clinical reasoning and reflection of clinical day using QSEN concepts.

60 Minutes- Students will chart utilizing EHR tutor and complete care plan.

Essential Clinical Objectives:

1. Integrates developmental considerations when performing head to toe pediatric assessment (cognitive).

Met Independently Met with Assistance Did Not Meet

1. Adapts communication skills and nursing interventions to meet developmental needs of child and family (psychomotor).

Met Independently Met with Assistance Did Not Meet

1. Integrates patient safety measures based upon developmental needs of child (cognitive.

Met Independently Met with Assistance Did Not Meet

1. Plans patient and family care utilizing assessment data, relevant policy and procedures and parent education resources (affective).

Met Independently Met with Assistance Did Not Meet

1. Evaluates patient and family responses to nursing interventions and revises plan of care accordingly (cognitive).

Met Independently Met with Assistance Did Not Meet

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| Patient Swift River vClinical |  |

Brief Intro to Scenario or Access EHR

**QSEN Concept of Evidence Based Practice:**

How will you provide Evidence Based Practice?

(GOC, Policies/Procedures, Reference Text)

Pre Team Huddle

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| Priorities of Care | Assessment related to Priorities of Care | What you Plan to do related to priorities of care  (Interventions) | What Cues might you interpret that would make you stop care and reassess? | Evaluation: |
| 1.  2.  3. | 1.  2.  3. | 1.  2.  3. |  |  |

**QSEN Concept of Safety:**

What might decompensation look like in this patient related to your priorities of care?

How would you keep your patient safe in this situation?

How would you escalate care?

What Bundles or Safety Precautions might be identified on the patient chart?

**QSEN Concepts of Informatics**

What trends or data in the chart could you access to support care?

Identify Areas of the Chart you would look to access care.

What Bundles or Safety Precautions might be identified on the patient chart?

**QSEN Concept of Teamwork:**

What communication strategies could use to escalate care?

Write out a SBAR (SBAR Rubric Found in Appendix A) or CUS situation based upon what decompensation might look like related to your priorities of care. Refer to Safety section for this situation.

What other interprofessional providers or services could you involve to provide high quality or patient centered care?

Why?

**QSEN Concept of Patient Centered Care**

How would you provide care based upon child’s expected development level? Include interactions based upon:

* communication- phrases you may use;
* activities you may engage in to facilitate coping, cooperation, development of milestones or developmental task
* Safety
* assessment considerations
* medication administration

Complete expected Development Appendix B

What immunizations would you expect this child to have or need? Reference CDC as needed.

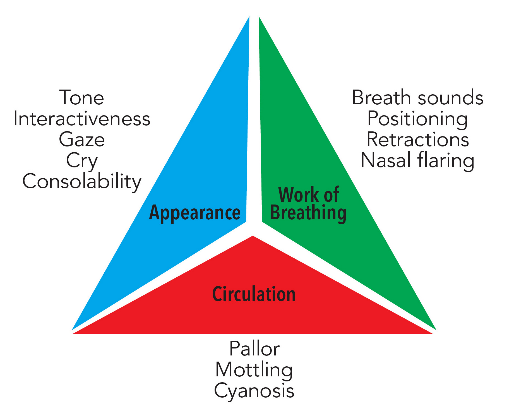
What patient teaching might you anticipate?

How would you assess Social Determinants of Health with the family?

Review your pre team huddle priorities of care & assessment

**Patient Care**: This section will be completed during your scenario as you gather information and information may be collected at the end as well if your missing information or need more details write the information or questions you would want to know in the section.

**Initial Assessment:**



A-

B-

C-

Sick or Not Sick

**Primary Assessment:**

A

B

C

D

E

**Systematic Assessment**:

Neurological

Respiratory

Cardiac

Gastrointestinal (GI)

Genitourinary (GU)

Skin

Labs

**After Scenario has Ended:**

Instructor will provide an unfolding case study component to build clinical judgment reflect on this scenario and how you would respond. Use SBAR to escalate care.

Select one patient education topic and be prepared to role play scenario.

Select one family education topic and be prepared to role play scenario.

Select one social determinant oh health to assess with your family.

Utilize Standard Report Sheet and be prepared to provide report on patient cared for

**QSEN Concept of Informatics:**

After your scenario has ended go to your EHR:

1. Chart your patient assessment
2. Create a nurses note
3. One set of vitals and assessment that would be a cue to escalate care to keep patient safe.
4. Document SBAR

**QSEN Concept of Patient Centered Care**

Reflect on one the patients you cared for this shift and the care provided.

1. Complete a Care Plan for 1 of your patients

**Post Team Huddle-**

Complete the On-Action Reflection sheet.

Be prepared to share your Care Plan summaries:

1 take away from learning linking assessment, interventions to your patient’s pathophysiology

SBAR

APPENDIX A Care Plan

**STUDENT NAME: DATE:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **CLIENT DEMOGRAPHIC INFORMATION** | | | | |
| **Client’s Initials:** | **DOB:** | **Age:** | **Wt:** | **Allergies:** |
| **Date(s) cared for:** | | | |

**SECTION I: PHYSIOLOGICAL ASSESSMENT & NURSING DIAGNOSES**

|  |
| --- |
| MEDICAL HISTORY: |
| Reason for Admission |
| Medical History |
| Current Medical Problems |
| Surgeries/Procedures |

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| --- | --- |
| **PATHOPHYSIOLOGY** | |
| **Current Medical Diagnoses/ Problems** | **How this relates to *this patient*** |
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| **RELEVANT LABORATORY FINDINGS** | | | | | | | | |
| **Date of Test** | **Test Name** | | **Patient’s Lab Finding** | | **Normal Range** | | **How does the value related to *this patient*? (Analyze trend)** | |
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| **VITAL SIGNS** | |  | |  | |  | |  |
| **Temperature** | |  | |  | |  | |  |
| **Heart Rate** | |  | |  | |  | |  |
| **Respiratory Rate** | |  | |  | |  | |  |
| **Blood Pressure** | |  | |  | |  | |  |
| **SaO2** | |  | |  | |  | |  |
| **Pain/ Scale Used** | |  | |  | |  | |  |

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| **MAINTENANCE FLUID CALCULATION**  (YOUR calculation of what you are *expecting* your patient to need based upon his/ her weight). How does this compare to patients current fluid requirement and intake/output status) | |
| **Daily Fluid Requirement:**  (cc/day)  Comparison: |  |

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| **SECTION II: DEVELOPMENT & PSYCHOSOCIAL ASSESSMENT** | |
| **DEVELOPMENTAL ASSESSMENT** | |
| **Expected Developmental Milestones** | **Actual Stage of Development**  **(How does *this patient* compare to expected milestones)** |
| 1. Nutrition |  |
| 2. Elimination |  |
| 3. Gross Motor |  |
| 4. Fine Motor |  |
| 5. Language |  |
| 6. Cognitive Development |  |
| 7. Self-Concept |  |
| 8. Roles and Relationships |  |
| 9. Coping and Resiliency |  |

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| **FAMILY ASSESSMENT** |
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**SECTION III: NURSING PROCESS:**

**Problem:**

**Risk factors:**

**General Goal:**

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| --- | --- |
| **Nursing Strategies /Interventions** | **Patient Responses** |
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**Evaluation: Summarize patient progress toward outcome objectives:**

Schuster, P.M. (2012). Concept Mapping: *A critical thinking approach to care planning(3rd ed).* Philadelphia, PA: FA Davis

**Problem:**

**Risk factors:**

**General Goal:**

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| **Nursing Strategies /Interventions** | **Patient Responses** |
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**Evaluation: Summarize patient progress toward outcome objectives:**

Schuster, P.M. (2012). Concept Mapping: *A critical thinking approach to care planning(3rd ed).* Philadelphia, PA: FA Davis

**Problem:**

**Risk factors:**

**General Goal:**

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| **Nursing Strategies /Interventions** | **Patient Responses** |
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**Evaluation: Summarize patient progress toward outcome objectives:**

Schuster, P.M. (2012). Concept Mapping: *A critical thinking approach to care planning(3rd ed).* Philadelphia, PA: FA Davis

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| **SCHEDULED MEDICATIONS** | | | | |
| **Drug / Drug Class** | **Target Dose/Range for *your patient***  (Calculated based upon patient Dose Calc. Weight) | **Dose, Route, Frequency** | **Why Ordered for *this Patient*** | **Priority Assessments & Interventions for *this patient*** |
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| **PRN MEDICATIONS (ADMINISTERED IN LAST 24 HOURS)** | | | | | | | | |
| **Drug / Drug Class** | | **Target Dose/Range for *your patient***  (Calculated based upon patient Dose Calc. Weight) | | **Dose, Route, Frequency** | | **Why Ordered for *this Patient*** | | **Priority Assessments & Interventions for *this patient*** |
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| **CONTINUOUS INFUSIONS** | | | | | | | | |
| **Infusion Name** | | | **Target Dose/Range for *your patient***  (Calculated based upon patient Dose Calc. Weight) | | **Why Ordered for *this Patient*** | | **Priority Assessments & Interventions for *this patient*** | |
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| **What are the relationships between the pathophysiology, psychosocial assessment, medications, labs, and treatments?** (You may draw a concept map – relationships between above items must be clear and detailed) | | | | | | | | | |
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| **SECTION V: ADDITIONAL INFORMATION** | | | | | | | | | |
| **DISCHARGE PLANNING: (What goals must be met before pt is discharged):**  **COMMUNITY/TEACHING RESOURCES** | | | | | | | | | |
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Appendix B

Clinical Reasoning in the Clinical: Reflection-ON-Action

Reflection-ON-action will deepen your development of knowledge and clinical judgment. In order to develop needed nurse thinking, it involves thorough and comprehensive reflection on a significant event in the clinical setting using the following framework:

* Description. Describe the patient situation
* Feelings. How did you feel? What were you thinking and feeling?
* Evaluation. How did you or others react? What problems did you experience? What challenged you?
* Analysis. Explore details by determining what was the real problem? Why were they encountered? What did you base judgments on? Were these assumptions accurate?
* Conclusion. Make a decision to determine what really happened. What was done well? What could have been differently? Could you have responded differently?
* Action plan. Where do you go from here? Make a plan to do what is needed to maximize learning. Is additional knowledge or training is needed?

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| Description: |
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| Feelings: |
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| Evaluation: |
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| Analysis: |
|  |
| Conclusion: |
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| Action Plan: |
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Adapted from: Tanner, C. A. (2006). Thinking like a nurse: A research-based model of clinical judgment in nursing. Journal of Nursing Education

Standard Report Sheet -located on Canvas

SBAR Rubric-located on Canvas

Professional Resources:

[CDC Immunization Link](https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html)

[Healthy People 2020 Social Determinants of Health](https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health)

[QSEN Competencies and Definitions](https://qsen.org/competencies/pre-licensure-ksas/)